BEFORE THE ARIZONA MEDICAL BOARD

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| In the Matter of<br>**MATTHEW DICKER, M.D.**<br>Holder of License No. 33711<br>For the Practice of Allopathic Medicine<br>In the State of Arizona. | **Case No. MD-14-1299A**<br>**ORDER FOR LETTER OF REPRIMAND; AND CONSENT TO THE SAME** |

Matthew Dicker, M.D. ("Respondent"), elects to permanently waive any right to a hearing and appeal with respect to this Order for a Letter of Reprimand; admits the jurisdiction of the Arizona Medical Board ("Board"); and consents to the entry of this Order by the Board.

## FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of license number 33711 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-14-1299A after receiving notification of malpractice settlement regarding Dr. Dicker's care and treatment of a 73 year-old male patient ("EE") alleging failure to perform urgent vascular intervention resulting in sepsis and death.

4. On July 12, 2012, EE presented to the emergency department ("ED") at the hospital where Respondent holds privileges with left lower leg pain described as constant and worsening and/or exacerbated by movement, along with 2 days of left lower back pain radiating into buttocks and back of leg. EE's history included degenerative disc disease, lower back pain for more than 5 years, chronic pain syndrome on Percocet, peripheral neuropathy on Neurontin, and obstructive sleep apnea. EE reported during this

admission that he had a history of peripheral vascular disease, a previous right leg amputation below the knee, hyperlipidemia, hypertension, and coronary artery disease, and a previous coronary artery bypass. An arterial ultrasound was completed with findings of occlusion of the posterior tibial-peroneal trunk, patent anterior tibial artery. Respondent provided a telephone consult and recommended follow-up in the Radiology clinic within 1-2 days. EE was discharged home with a diagnosis of low back pain with exacerbation.

5. Respondent saw EE on July 13, 2012. Respondent diagnosed EE with progressive non-acute peripheral vascular disease ("PVD") with worsening left leg rest pain and ordered an angiogram with intervention. Respondent documented that EE's pulses were absent on Doppler with three seconds capillary refill.

6. On July 19, 2012, EE returned to the ED with lower leg pain exacerbated by movement. EE's physical exam noted that the left lower extremity was cool, with a +1 dorsalis pedal pulse with a good capillary refill, and the foot was pink and warm. The ED provider diagnosed EE with peripheral vascular complications without neurovascular compromise with good pulses; he ordered a CT angiogram and placed a call to Respondent who examined the patient. Respondent's performed an examination that was not documented other than that he examined the patient, found that he did not need acute intervention and recommended outpatient work-up. Respondent confirmed that the outpatient angiogram was scheduled for July 26, 2012, and re-scheduled it a day later so he could personally perform it on July 27, 2012.

7. On July 25, 2012, EE returned to the ED with acute left lower extremity ischemia with a cold, blue, and painful extremity with no pulses. EE was transferred to a Heart Hospital and died on August 4, 2012 with a cause of death listed as shock secondary to severe leg ischemia.

8. The standard of care required Respondent to perform a semi-urgent angiogram in a patient such as EE. Respondent deviated from this standard of care by failing to perform a timely semi-urgent angiogram on a patient with progressive symptoms of that could represent vascular compromise.

9. The standard of care required Respondent to document his vascular examination. Respondent deviated from this standard of care by conducting a vascular examination without documentation of his findings on July 19, 2012.

## CONCLUSIONS OF LAW

a. The Board possesses jurisdiction over the subject matter hereof and over Respondent.

b. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(e)("Failing or refusing to maintain adequate records on a patient.").

c. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(q)("Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.").

## ORDER

IT IS HEREBY ORDERED THAT:

1. Respondent is issued a Letter of Reprimand.

DATED AND EFFECTIVE this 5th day of August, 2016.

ARIZONA MEDICAL BOARD

By Patricia E. McSorley
Patricia E. McSorley
Executive Director

## CONSENT TO ENTRY OF ORDER

1. Respondent has read and understands this Consent Agreement and the stipulated Findings of Fact, Conclusions of Law and Order ("Order"). Respondent acknowledges he has the right to consult with legal counsel regarding this matter.

2. Respondent acknowledges and agrees that this Order is entered into freely and voluntarily and that no promise was made or coercion used to induce such entry.

3. By consenting to this Order, Respondent voluntarily relinquishes any rights to a hearing or judicial review in state or federal court on the matters alleged, or to challenge this Order in its entirety as issued by the Board, and waives any other cause of action related thereto or arising from said Order.

4. The Order is not effective until approved by the Board and signed by its Executive Director.

5. All admissions made by Respondent are solely for final disposition of this matter and any subsequent related administrative proceedings or civil litigation involving the Board and Respondent. Therefore, said admissions by Respondent are not intended or made for any other use, such as in the context of another state or federal government regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or any other state or federal court.

6. Upon signing this agreement, and returning this document (or a copy thereof) to the Board's Executive Director, Respondent may not revoke the consent to the entry of the Order. Respondent may not make any modifications to the document. Any modifications to this original document are ineffective and void unless mutually approved by the parties.

7. This Order is a public record that will be publicly disseminated as a formal disciplinary action of the Board and will be reported to the National Practitioner's Data Bank and on the Board's web site as a disciplinary action.

8. If the Board does not adopt this Order, Respondent will not assert as a defense that the Board's consideration of the Order constitutes bias, prejudice, prejudgment or other similar defense.

9. ***Respondent has read and understands the terms of this agreement.***

Matthew Dicker DATED: 7.27.16
MATTHEW DICKER, M.D.

EXECUTED COPY of the foregoing mailed this 5th day of August, 2016 to:

Matthew Dicker, M.D.
Address of Record

ORIGINAL of the foregoing filed this 5th day of august, 2016 with:

Arizona Medical Board
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

Mary Bobey
Board Staff